ARIZONA DEPARTMENT of HEALTH SERVICES
Office for Children with Special Health Care Needs

INTAKE FORM

INITIAL INTAKE ☐ **REOPEN ☐** **EMERGENCY INTAKE ☐**

PROGRAM: ☐ CYSHCN ☐ TBI ☐ SCI

MEMBER'S INFORMATION

EMERGENCY INTAKE

Referral Date	Intake Date	Referral Source	Phone # - -

Last Name	First Name	MI	Gender	DOB	SSN

Physical Address	City	State	ZIPCODE -	County	Phone # - -
Mailing Address	City	State	ZIPCODE -	County	Cell Phone # - -

Race/Ethnicicity	Tribe	Reservation	Primary Language

Home School District	Current School	Has Returned to School YES NO

Agency Involvement

ACYF CPS DDD Foster Care Other _____

Current Placement

Home Hospital _____ Rehab _____ Residential/Independent Living _____ Other

Insurance Coverage

AHCCCS Kids Care ALTCS Medicaid IHS County Funded Private None/Self-Pay

Health Plan	ID #	Name of Insured
Insurance Company Name	ID #	Name of Insured

RESPONSIBLE PERSON (S)/CAREGIVER (S) INFORMATION

Last Name	First Name	MI.	Relationship to Child

Address	City	State	ZIPCODE -	County	Phone # - -
Mailing Address	City	State	ZIPCODE -	County	Cell Phone # - -

MEDICAL INFORMATION

Primary Care Physician (Last Name, First Name)	Address	Phone Number - -	FAX - -
Neurologist (Last Name, First Name)	Address	Phone Number - -	FAX - -

Presenting Problem	Immunizations Current Yes No Exemption/Refused	Current Health Status

Date of Injury/Illness	Age at time of Injury/Illness	Cause of Injury/Illness	Type of Injury/Illness

Outpatient Services Needed/ Will Receive

Home Health Services Needed/Will Receive

FAMILY RESOURCE COORDINATION

Family Resource Coordinator (Last Name, First Name)	Contractor	Phone Number - -	FAX - -

Information/Referrals Family Needs Immediately

Specific Family Concerns

Follow-Up